David J Posey MD, LLC
9106 N Meridian St
Suite 210
Indianapolis, IN 46260
Tel No. 317-341-4575
Fax No. 317-706-0249

AUTHORIZATION FOR RELEASE OF INFORMATION

Name of Person/Entity to release/receive info to/from	
Street	
City, State, Zip	
Tel No.	
Fax No.	

I, _____, authorize
Name of Patient (Date of Birth)

Dr. Posey to give and receive information concerning my medical, mental health, and/or drug and alcohol treatment to and from the person/entity listed above.

I understand that I may revoke this authorization at any time, except to the extent that action has already been taken in reliance upon this authorization. I understand that no treatment, payment, enrollment or eligibility for benefits may be conditioned on whether I sign this authorization except as allowed under the HIPAA regulations. David J Posey MD, LLC and Dr. Posey are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. The information used or disclosed pursuant to the authorization may be further disclosed by the recipient and no longer protected by federal law, except for drug and alcohol treatment information. I understand that I am entitled to a copy of this authorization.

Date: _____ Signature: _____
Patient (age 13 and older)

Signature: _____
Parent/Guardian